NATURALLY OCCURRING RETIREMENT COMMUNTIES

An Introduction

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The articles by Anita Altman and Jenny Brodsky describe two models of targeted service delivery to older people, the Naturally Occurring Retirement Community-Supportive Service Program (NORC-SSP), initially developed by UJA Federation in New York City, and the Supportive Community Program, created by ESHEL — The Association for the Planning and Development of Services for the Aged in Israel and the Israel Ministry of Social Affairs. Both models deliver services designed to help older people remain independent and age in their own homes, rather than in institutional care. Both were developed through the Jewish community, but within varying cultures; thus, the models share similar values, but differ significantly in their service context, goals, and implementation.

The desire to age in place is fairly universal. According to William D. Novelli (2002), now CEO of the American Association of Retired Persons (AARP), 85 percent of older people surveyed by AARP want to continue living where they are — at home. The challenge for service providers is how to make "home" more elder friendly. Another issue is defining how big "home" is — is it an apartment, a floor of a building, a housing development, a city block, a suburban neighborhood, or a census tract? How can we transform communities that were initially designed for young families and healthy adults into places that embrace, engage, and support older residents? What are the challenges and opportunities inherent in doing so?

In the United States, specialized community-based services to help older people were first developed with the passage of the 1965 Older Americans Act and the creation of Medicare. In many communities there are congregate and home-delivered meal programs, case assistance, and information and referral services, along with social and recreational programming offered through senior centers that are supported in part through Older Americans Act funding from the federal government. Improved access to health care (in great part because of the success of Medicare), new medical technologies, and effective medications for managing chronic conditions have all contributed to lengthening life expectancy. Today, an American who reaches age 65 can expect to celebrate her 84th or his 81st birthday (U.S. HHS, 2003).

The vast majority of oldest Americans, people aged 85 or older, live in the community. In 1999 only 18 percent of Americans aged 85 or older resided in nursing homes (Centers for Disease Control and Prevention, National Nursing Home Survey). Instead, elders are managing chronic conditions like hypertension, arthritis, and heart disease at home. However, over time, individual elders' needs change, and increasingly supportive services are required to keep them safe and independent, in the community.

Where people age has much to do with where they spent their adult years — only 6 percent of America's elders live in the "Leisure World" or "Sun City" communities specifically planned and built for retirees. Instead, many retirees live in the general community but in proximity to other elders. According to *U.S. News and World Report* (Perry, 2001), one in four retirees lives in a community where at least half of the residents are older than age 60. AARP (2005) estimates that between 27 and 33 percent of seniors live in communities with significant concentrations of other older adults. An urban elder surrounded by neighbors he or she

has known for many years, with a grocery store, post office, and bank within a few blocks, and accessible public transportation has vastly different needs from a single-family homeowner in the suburbs, who must travel by car to get even basic essentials and may not know his or her neighbors by name, only by face. The service contexts differ as well — the density and diversity of services offered in an urban setting as contrasted with a single congregate meal site or senior center in a suburban town. These articles highlight these distinctions as well.

BASKETS OF SERVICES — ONE SIZE DOES NOT FIT ALL

Both the NORC-SSP and the Supportive Community Program offer improved access to services that help elders remain independent in their own homes. For families, they provide peace of mind, and for elders, a sense of security. However, it is clear that the "core" services in the NORC-SSP model and the "basket of services" available in the Supportive Community Program evolved in different contexts.

The NORC–SSP model takes advantage of the service-rich urban environment, focusing on increasing access and awareness of existing services through case assistance, information and referral, and preventive health services. It focuses on helping participants make connections – to service providers, one another, and the broader community. It does so through self-governance by the older participants, voluntarism within the program, and creating group programming opportunities that foster new friendships or capitalize on existing connections between participants. "Classic" NORC-SSPs are located in apartment buildings with high density and often engage neighbors who have lived in close proximity for years. The NORC-SSP helps these older residents articulate shared interests and then advocate as a recognizable group to building management, community organizations, and local officials. Ultimately, the community, local government, service providers, and the housing entity become partners and stakeholders in service development and delivery.

In contrast, the Supportive Community Program focuses more on direct delivery of specific services otherwise unavailable to an elder. Rather than coordinating and facilitating the efforts of many service providers working together through a lead nonprofit agency, the Supportive Community Program serves as a single portal for access and may be administered by either a nonprofit or for-profit organization.

Each Supportive Community Program serves approximately 200 households with older adults (age 65+) distributed within a specific geographic area of between 5 and 10 kilometers (3 to 6 miles). Households are enrolled as members and pay a membership fee, which may be subsidized. Membership entitles a household to a core basket of services: medical services (house calls from a physician and ambulance service), a 24-hour emergency switchboard, household repairs, and social activities. Program staff members are expected to be familiar with locally available services and make referrals when necessary. In this model, member households first develop connections to their neighborhood facilitator (who makes repairs, visits, and may assist with some errands) and the switchboard staff.

GENESIS AND SUSTAINABILITY

As described in Anita Altman's article, the NORC-SSP evolved from a community-organizing base with volunteers, engaged nonprofit service providers in a new delivery system, attracted philanthropic support, and then garnered government funding through effective advocacy with New York City and State. In contrast, the Supportive Community Program was initiated centrally in Israel and planned "top down" on a national level. Each supportive community program is administered locally, but within a national framework.

Sustainability differs as well, with "classic" NORC-SSPs combining government funding with private matching dollars and support from housing entities to build a program budget. Because one of the functions of a NORC-SSP is to link participants with

existing services, little fee-for-service income is generated. Israel's Supportive Community Programs start with an initial 3-year grant and must wean themselves from national funding by building a fee-paying membership base. Some fee-for-service elements, such as a nominal charge for a physician house call and optional transportation services that can be purchased, are built into the model. However, the ability of both programs to remain solvent depends primarily on achieving customer satisfaction and retention.

CHALLENGES AND NEXT STEPS

The rich New York City service context and the cultural imperative of Israel's centralized planning effort are integral to these service models. However, in the United States, most adults age in the suburbs, without the service efficiency of urban density or the cohesion of Israeli national identity. Can these models teach us concepts that will help us serve elders who are aging in place at the end of cul-de-sacs and snowy driveways? It appears so.

Since 2001 both UJA-Federation of New York and United Jewish Communities' (UJC) Washington Action Office have been working to create neighborhood supportive service programs that address a broader range of service contexts, not just in urban settings but also in lower density garden apartment complexes, suburban areas, and single-family homes. Altman's article describes the NORC without Walls effort, which is adapting NORC-SSP programs and targeting 1,800 single-family homes with more than 900 seniors.

In addition, UJC has led national advocacy efforts and secured $22.2 million in federal funds for 41 communities to pursue demonstration grants using the NORC-SSP principles to help elders age in place. These public funds offer Jewish communities new opportunities to work collaboratively with other local service providers, as they coordinate nonduplicative services that enhance the independence of seniors aging in place. In Las Vegas, the Jewish community has spearheaded a centralized information and referral service for seniors; in Los Angeles, the LIFE program provides visiting nurses and social workers in the Park La Brea garden apartments; and in Bergen County, New Jersey, volunteer architects are designing ramps for elders living in single-family homes through an Aging in Place initiative.

As the Jewish community increasingly includes a greater percentage of elders, many without children nearby or family readily available, it is imperative that our service models continue to evolve. Our elders' desire to live at home, stay healthy, remain connected to the community in a meaningful way, and manage their affairs independently is clear. These articles give excellent insights about how we can respond creatively to the service opportunities generated by increased longevity and the challenges of our changing demography.

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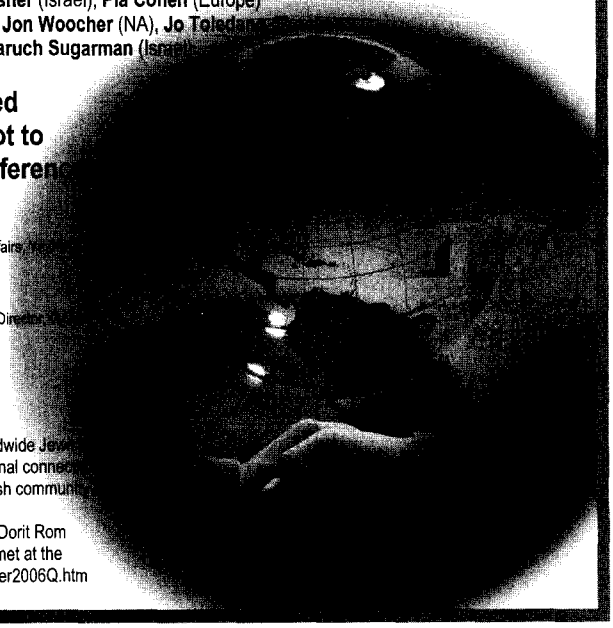

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